DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 1 4

2. STATE: MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subparts B & C

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 500,000.00
b. FFY 2004 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages 8, 15, 16, 27, 28.1, 28.2, AppendixA
Page 5, Page 24.8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 8, 15, 16, 27, 28.1, 28.2, Appendix A

10. SUBJECT OF AMENDMENT:
Update DRG Grouper, GME Payment Clarification

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Paul Reinhart, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Paul Reinhart

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Director

15. DATE SUBMITTED: 9-26-2003

16. RETURN TO:
Medical Services Administration
Program Policy - Federal Liaison Unit
400 South Pine, 7th Floor
Lansing, Michigan 48933
ATTN: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 29 2003

18. DATE APPROVED: SEP 14 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carmen Keller

22. TITLE: DEPUTY Director, CMSO

23. REMARKS: Period change to block # 8

RECEIVED
SEP 29 2003
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

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- Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of multiple page claims where there is no initial claim containing a valid patient status);

- Eliminate episodes with a zero dollar Medicaid liability;

- Determine the 3rd and 97th percentile length of stays by DRG, the average length of stay, and the maximum length of stay.

  - Set the low day outlier threshold at the greater of one day or the 3rd percentile length of stay.

  - Set the high day outlier threshold at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay.

  - If the DRG has less that an adequate number of episodes (currently 32), the low day threshold will be set at the lesser of the average length of stay plus 30 days, the maximum length of stay, or the Medicare DRG 90th percentile length of stay (from the corresponding Grouper as published in the Federal Register). If the Medicare DRG also has an inadequate number of claims, then the threshold is set based upon the expert advice of the MSA's medical staff.

- Eliminate low day outliers (Low day outliers are those episodes whose length of stay are less than the published low day threshold for each DRG. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio times charges, and do not receive a DRG payment, they are excluded from the weight calculations);

- Calculate the arithmetic mean length of stay for each DRG with each episode's length of stay limited to the high day threshold set above. This serves as the final published average length of stay.

- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (for DRGs 385 and 385.1 all transfers are included);

- Bring all charges for admissions in the first and second years of the base period up to third year charges through application of inflation and weighting factors;

- Recognize area cost differences by dividing the charges for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Metropolitan Statistical Areas (MSAs) for wage data as published in the Federal Register. The most recent data available is used. Each area cost adjustor is calculated as follows:

  - Cost Adjustor = 0.9 x Wage Adjustor + 0.1
  - This formula is the algebraic deviation of:
    - 0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

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- The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG.

- The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG is included in Appendix A.

- Bring all charges for discharges between September 1, 1997 and August 31, 1999 to the period of September 1, 1999 through August 31, 2000 through application of inflation and weighting factors.

Data for current wage adjustors are taken from hospital cost reporting periods ending between September 1, 1997 and September 30, 2000. Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time. The following adjustment factors derived from the 2nd Quarter 2002 Data Resources, Inc. PPS-Type Hospital Market Basket Index, employee cost component, are used:

FTE	Wage Inflation Factors	Wage Weighting Factors
9/30/97	1.1065	0.16
12/31/97	1.0980	0.16
3/31/98	1.0890	0.16
6/30/98	1.0799	0.16
9/30/98	1.0708	0.24
12/31/98	1.0625	0.24
3/31/99	1.0544	0.24
6/30/99	1.0463	0.24
9/30/99	1.0388	0.60
12/31/99	1.0302	0.60
3/31/00	1.0209	0.60
6/30/00	1.0107	0.60
9/30/00	1.0000	0.60

For hospitals with cost reporting periods ending other than at the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

B. DRG Price:

The episode file used for DRG price calculations is the same as the file used to set the relative weights with the following exceptions:

- The episode file is limited to those hospitals enrolled as of a specified date.

- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.

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FTE	Cost Inflation Factors	Weighting Factors
9/30/97	1.0921	0.16
12/31/97	1.0856	0.16
3/31/98	1.0785	0.16
6/30/98	1.0699	0.16
9/30/98	1.0614	0.24
12/31/98	1.0537	0.24
3/31/99	1.0470	0.24
6/30/99	1.0412	0.24
9/30/99	1.0354	0.60
12/31/99	1.0283	0.60
3/31/00	1.0196	0.60
6/30/00	1.0100	0.60
8/31/00	1.0000	0.60

The inflation update for the quarter in which the hospital's fiscal year ends is used.

- Recognize area cost differences by dividing the cost per day for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Metropolitan Statistical Areas (MSAs) for wage data as published in the Federal Register. The most recent data available is used. Each area cost adjustor is calculated as follows:

  - Cost Adjustor = 0.9 x Wage Adjustor + 0.1
  - This formula is the algebraic derivation of:

    0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

    The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.

  - Each area wage factor is area wage per full-time equivalent (F.T.E.) divided by the statewide average hospital wage per F.T.E. Contract labor costs are included in determining a hospital's wage costs.

  - Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time. The following adjustment factors, derived from the 2nd Quarter 2002 Data Resources, Inc. PPS-Type Hospital Market Basket Index, employee cost component, are used:

FTE	Wage Inflation Factors	Wage Weighting Factors
9/30/97	1.1065	0.16
12/31/97	1.0980	0.16

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3/31/98	1.0890	0.16
6/30/98	1.0799	0.16
9/30/98	1.0708	0.24
12/31/98	1.0625	0.24
3/31/99	1.0544	0.24
6/30/99	1.0463	0.24
9/30/99	1.0388	0.60
12/31/99	1.0302	0.60
3/31/00	1.0209	0.60
6/30/00	1.0107	0.60
9/30/00	1.0000	0.60

For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

- ➢ The wage data for distinct part rehabilitation units is the same as for the inpatient medical/surgical area of the hospital. The cost reports do not differentiate salaries/hours by unit type.

- ➢ If two or more hospitals merge and are now operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data will be inflated to a common point in time.

- Remove indirect medical education (IME) costs by dividing by an adjustor for indirect education. Each hospital's IME adjustor is calculated as follows:

  - ➢ $IME\ Adjustor = 1 + 0.715 \times [(1 + Interns\ \&\ Residents/Beds)^{0.5795} - 1]$

  - ➢ Distinct part rehabilitation units report this data separately. The IME adjustor is unique to the unit.

  - ➢ If two or more hospitals merge and are now operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

To determine the per diem rate:

- Calculate the statewide operating cost limit (by provider type). This is a weighted mean of all hospitals' specific base prices weighted by base period days (truncated mean), multiplied by the appropriate percentage.

  - ➢ For freestanding rehabilitation hospitals the percentage is 150%.

  - ➢ The 50th percentile is determined by calculating a standardized rate for each unit. The standardized rate for all enrolled Michigan units are sorted

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d. A special DSH pool of $2,291,476 is being created for FY'02. The purpose of the pool is as follows:

- Assure continued access to medical care for indigents,
- Develop cancer prevention and control programs, and
- Increase the efficiency and effectiveness of cancer treatment for Medicaid beneficiaries.

Participation in this pool will be limited to hospitals that meet the following requirements:

- The minimum federal requirements for DSH eligibility as listed in Section III. H.
- Have in place an agreement approved by the Department between itself and a university with a college of allopathic medicine. The agreement must include provisions for the development of cancer prevention and control programs.
- The agreement must include a schedule of activities and a budget.

Only one agreement per year will be approved per university.

The payment amount from this special DSH pool will be specified in the approved agreement. The payment amount is subject to the maximum allowable DSH payment for the hospital for the state fiscal year including all other DSH payments.

3. Public Hospitals DSH Sunset Provision

Medicaid DSH payments to public hospitals are made up to the public hospital DSH ceiling as permitted by current federal regulations.

These payments are authorized to continue through September 30, 2005. The state may submit state plan amendments effective after September 30, 2005 that re-implement the current payment structure or different payment methodologies.

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The add-on amount is an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

J. Graduate Medical Education

Dental & Podiatry Residency Programs

To obtain an average FTE payment for dental and podiatry residents, the GME liability for those hospitals operating only dental and podiatry residency programs will be summed. Each hospital's GME liability will be taken from calendar year 1995 estimates of GME liability used to make GME payments to hospitals between July 1, 1997 and December 31, 2001. The summed total of these liabilities will be divided by the total number of dental and podiatry FTEs (for the same hospitals that the liability data is drawn). The FTEs will be drawn from hospital cost reports from the first state fiscal year for which complete data is available. The product will be an average dental and podiatry FTE dollar payment to all hospitals reporting these FTEs.

Annually each hospital reporting dental and podiatry FTEs will be reimbursed the average dental and podiatry FTE payment as calculated above for each of its dental and podiatry FTEs. Hospital FTEs will be drawn from hospital cost reports for the most recent state fiscal year for which complete data is available (this will be the same FTE count used to distribute the GME Funds and Primary Care Pools).

The dental and podiatry FTE payments made to all hospitals will be summed and the total will be deducted from the GME Funds Pool before any other distributions are made from this pool.
Once the dental and podiatry FTE payments have been deducted, the remaining funds in the GME Funds Pool will be distributed as described below in the sections labeled GME Funds Pool and Primary Care Pool.

Each hospital's dental and podiatry FTE count and the total dollar amount allocated to pay hospitals for dental and podiatry FTEs will be updated annually. The average dental and podiatry FTE dollar payment will not. The average dental and podiatry FTE dollar payment will only be adjusted when the GME Funds and Primary Care Pools are adjusted. Any adjustment to the average dental and podiatry FTE dollar payment will be proportional to the changes in these two pools.

Distribution of GME Funds
Distribution of graduate medical education funds will be calculated annually to coincide with the state fiscal year (October 1 to September 30) for two formula pools – the GME Funds and the Primary Care Pools. In order to receive funds for graduate medical education, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. Payments will be fixed, prospective payments, made in full and are not subject to future cost settlement, or appeal. Payments will be made only to hospitals that provide requested information by the dates required. Payments will be made semi-monthly by gross adjustment. Separate gross adjustments will be made for each pool payment.

Only intern and resident FTEs in approved programs as specified in *Federal Regulations* (see 42 CFR 413.86) will be eligible for inclusion in the data used to calculate the distribution of the GME Funds and Primary Care Pools.

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$$FTEs \times Casemix \times (Hospital's\ TV\ \&\ TXIX\ Days / Hospital's\ Total\ Days) = Adjusted\ FTEs$$

$$[0.05 \times \$162.7\ Million \times \frac{Hospital's\ Board\ Certified\ Physicians}{\Sigma\ Board\ Certified\ Physicians}] + [0.05 \times \$162.7\ Million \times \frac{Hospital's\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}{\Sigma\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}] +$$
$$[0.9 \times \$162.7\ Million \times (Adjusted\ FTEs / \Sigma\ Adjusted\ FTEs)] = Pool\ Distribution$$

Primary Care Pool
The total dollar amount of this pool will be $20 million of the total GME appropriation. To calculate each hospital's share of the Primary Care Pool, the following formula will be used:

$$FTEs \times (Hospital's\ TV\ \&\ TXIX\ Outpatient\ Charges / Hospital's\ Total\ Charges) = Adjusted\ FTEs$$

$$[0.05 \times \$20\ Million \times \frac{Hospital's\ Board\ Certified\ Physicians}{\Sigma\ Board\ Certified\ Physicians}] + [0.05 \times \$20\ Million \times \frac{Hospital's\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}{\Sigma\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}] +$$
$$[0.9 \times \$20\ Million \times (Adjusted\ FTEs / \Sigma\ Adjusted\ FTEs)] = Pool\ Distribution$$

Definitions/Notes
Title V & Title XIX Days – includes fee-for-service and managed care days. Days will include those from distinct-part psychiatric and distinct-part rehabilitation units.
Title V & Title XIX Outpatient Charges – includes fee-for-service and managed care outpatient charges. Charges will include those from distinct-part psychiatric units.
# of Residents Board Certified – number of residents board certified 3 years after completion of residency from a hospital. Hospital's Case Mix – the sum of the relative weights for all Medicaid admissions divided by the number of Medicaid admissions during the period covered.
# of Physicians Enrolled in the Michigan Medicaid Program 3 years after completion of residency from a hospital.
# of Hospital Eligible Resident FTEs – for the GME Funds and Primary Care Pools FTE data will be drawn from hospital cost reports as indicated above.

Implementation of Weighting Factors
The 5 percent weighting factors for physician participation in the Michigan Medicaid program and board certification will not be implemented until July 1, 2004. Until then, the above distribution formulas, without the weighting factors, will be used to distribute GME funds from the *GME Funds* and the *Primary Care Pools*.

However, to gain experience and to assess the impact of the new policy and formulas, hospitals will be required to begin reporting resident data in the Spring 2002. In order to implement the

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weighting factors for both physician participation in the Medicaid program and board certification, the department will use a five-year rolling average.

Based on information included in a hospital's report, the department will calculate the number of hospital residents participating in the Michigan Medicaid program. A physician must receive a minimum of $2,000 in payments from the Medicaid program, in the fiscal year that hospital cost report data is drawn, to be included in the "Physicians participating in the Medicaid program" weighting factor.

Hospitals will report on the board certification status of residents that completed their residency programs a minimum three years prior to the fiscal year that hospital cost report data is drawn in order to calculate the distribution of funds from the GME pools. Hospitals may report a physician that has been board certified each time the physician passes a board examination and is awarded certification during a five-year rolling average period.

Additional information regarding reporting requirements will be included in the report sent to hospitals for completion.

Three Year Phase- In of Revised GME Formula
In order to reduce the short-term impact that the revised formulas and distributions of GME funds will have on any hospital, the department will use a three-year phase in period. During the first full year, GME payments will be based three quarters on the prior distribution as established in MSA Bulletin 96-15, issued December 16, 1996, and one quarter based on the revised formula published in this bulletin. During the second year (beginning October 1, 2003), the ratios will be one half each. In the third year (beginning October 1, 2004), payments will be based on one quarter of the old formula and three quarters of the new formula. In the fourth year (beginning October 1, 2005), GME payments will be made based entirely on the new formula.

GME Payments will be Prorated for the Current Academic Year
For the July 1, 2001 to June 30, 2002 academic year and payment period, GME payments will be prorated. During July 1 to December 31, 2001, GME payments will be calculated using the prior GME reimbursement schedule. For January 1 to June 30, 2002, GME payments will be calculated using the new formulas indicated above. Thereafter, the new formulas will be used to annually calculate and distribute GME funds appropriated by the legislature.

GME Innovations Grants
To encourage the training of health professionals for the future health care environment, a special pool will be established which will be distributed to projects or organizations that wish to develop innovative health professions education programs. The pool will be established bi-annually. The size of the pool will be subject to the availability of funds for the same state fiscal year in which payments for services are made. Competitive grants will be awarded to qualified applicants that respond to a request for proposal (RFP) issued by the department for this purpose. Grants will be awarded to projects that support public policy goals and priorities, as specified in the "Guiding Principles" above, and included in the RFP to be issued.

Grants will be awarded only for health professions education programs that are accredited by national and/or regional accrediting agencies. Improved care and treatment of Michigan Medicaid patients must be the focus of any grant awarded. Payments will be limited to enrolled Medicaid providers that will act as the fiduciary for the grantee. Grants may be